STATE OF MICHIGAN
IN THE SUPREME COURT

JOHANNA WOODARD and STEVEN WOODARD Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor,

Plaintiffs/Cross-Appellants,

vs.

JOSEPH R. CUSTER, M.D.,

Defendant/Cross-Appellee,

and

JOHANNA WOODARD and STEVEN WOODARD, Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor

Plaintiffs/Cross-Appellants,

vs.

UNIVERSITY OF MICHIGAN MEDICAL CENTER,

Defendant/Cross-Appellee.

Supreme Court Docket: 124994-95

Court of Appeals Docket: 239868

Washtenaw Circuit Court No: 99-5364-NH

CONSOLIDATED WITH

Court of Appeals Docket: 239869

Court of Claims No: 99-17432-CM

AMICUS CURIAE BRIEF OF THE MICHIGAN TRIAL LAWYERS ASSOCIATION

EXHIBITS

PROOF OF SERVICE

Submitted by:

MARK R. BENDURE (P23490)
Attorneys for Amicus Curiae
Michigan Trial Lawyers Association
645 Griswold, Suite 4100
Detroit, Michigan 48226
(313) 961-1525

TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases	Page(s)
Woodard v Custer, 473 Mich 1; 701 NW2d 133 (2005)	1
Woodard v Custer, 473 Mich 856; ___ NW2d ___ (2005)	13
Woodard v Custer, Ct. of App. # 239868, unpublished *per curiam* Opinion, *rel'd* 10/21/03	1

STATUTES, COURT RULES AND OTHER AUTHORITIES

STATEMENT OF QUESTIONS PRESENTED

I. BY THE LANGUAGE OF MCLA 600.2169, HAS THE LEGISLATURE EXPRESSED THE POLICY JUDGMENT THAT AN EXPERT WITNESS WHO IS BOARD-CERTIFIED IN THE SAME SINGLE "SPECIALTY" AS THE DEFENDANT IS STATUTORILY QUALIFIED, AND SHOULD THIS COURT NOT CREATE A JUDGE-MADE "SUB-SPECIALTY" REQUIREMENT WHICH THE LEGISLATURE ABJURED?

Amicus answers "YES".

B. DOES THE LANGUAGE CHOSEN BY THE LEGISLATURE IN MCLA 600.1629 REQUIRE MATCHING A SINGLE "SPECIALITY"?

Amicus answers "YES".

C. DOES THE STATUTORY LANGUAGE OF MCLA 600.2169(1), WHICH THIS COURT SHOULD RESPECT, REQUIRE AN EXPERT WITNESS TO MATCH A SINGLE ("THAT") "SPECIALTY"; AND DOES NOT REQUIRE MATCHING "SUB-SPECIALTIES" OR MULTIPLE SPECIAL-TIES?

Amicus answers "YES".

STATEMENT OF FACTS

Amicus Michigan Trial Lawyers Association ("MTLA") will leave it to the parties to present the facts they deem significant to the outcome of this particular case. The interest of MTLA is primarily in the broader questions framed by this Court in its Order granting leave. Accordingly, for purposes of this Brief, Amicus adopts the essential facts recited in the Opinion of the Court of Appeals [***Woodard v Custer*, Ct. of App. # 239868,** unpublished *per curiam* Opinion, *rel'd* 10/21/03 (hereafter, "Opinion")].[1]

In this medical malpractice suit, the remaining Defendants are Dr. Custer and the University of Michigan Medical Center (Opinion, p. 2). According to Plaintiff, liability is grounded in general pediatric medicine (Opinion, p. 4). Doctor Custer is board-certified in the specialty area of pediatrics (Opinion, p. 6). Plaintiff's proposed expert witness, Dr. Casamassima, is likewise board-certified in pediatric

---

[1]The Court of Appeals decision arose from three separate Opinions. Judges Meter and Borello agreed that the case was maintainable under *res ipsa loquitur* principles, a view that this Court rejected in earlier review of this case, ***Woodard v Custer*, 473 Mich 1; 701 NW2d 133 (2005).**

Judges Talbot and Meter agreed on the issue now before this Court: that Plaintiff's proposed expert witness was statutorily disqualified. The discussion of this point is found in Judge Talbot's Opinion. Consequently, the designation "Opinion" refers to the Opinion of Judge Talbot, with which Judge Meter concurred on the expert witness question.

medicine (Opinion, p. 4).

According to the Court of Appeals Opinion, Dr. Custer is also board-certified in pediatric critical care medicine and neonatology-perinatology[2] (Opinion, p. 6). Dr. Casamassima was not board-certified in these additional fields.

The principal dispute focuses on whether Dr. Casamassima satisfies the statutory expert witness requirements of **MCLA 600.2169(1)(a)** (". . . if the party against whom or on whose behalf the testimony is offered is a specialist who is board-certified, the expert witness must be a specialist who is board certified in that specialty") and **MCLA 600.2169(1)(b)** (the witness must spend a majority of his or her time in, "if [the defendant] is a specialist, the active clinical practice of that specialty"). According to one view, Dr. Casamassima qualifies under the statute because he, like Dr. Custer, is board-certified in the specialty of pediatric medicine. Under the competing view, this is insufficient to satisfy the statute because Dr. Casamassima is not board-certified in pediatric critical care medicine and/or neonatology-perinatology.

In ruling on a pre-trial motion, the trial court struck Dr. Casamassima as an expert witness on the ground that he was not qualified under **MCLA 600.2169** (Opinion, p. 3). In so ruling, the trial judge viewed the statute as requiring an expert

---

[2]As discussed in the body of this Brief, "pediatric critical care medicine" and "neonatology-perinatology" are not truly "specialties", but are in fact "subspecialties".

witness to match the same subspecialties as the Defendant (Opinion, p. 6).

On appeal, the Court of Appeals affirmed, but on different grounds. Viewing the ruling as discretionary in nature, reversible only for abuse (Opinion, p. 4), Judges Talbot and Meter concluded that the witness was statutorily disqualified because he was not board-certified in pediatric critical care (Opinion, p. 6). Dissenting on this point, Judge Borello adopted the same standard of review (Borello Opinion, p. 3), but believed that Dr. Casamassima was qualified because he, like Dr. Custer, was board-certified in pediatric medicine, which Judge Borello regarded as the relevant specialty (*Id*, pp. 3-4).

By Order of July 12, 2005, the Court granted Plaintiff's Cross-Application for Leave to Appeal. That Order identified five related questions for consideration:

> "The parties are directed to include among the issues to be briefed: (1) what are the appropriate definitions of the term "specialty" and "board certified" as used in M.C.L. § 600. 2169(1)(a); (2) whether either "specialty" or "board certified" includes subspecialities or certificates of special qualifications; (3) whether M.C.L. § 600.2169(1)(b) requires an expert witness to practice or teach the same subspecialty as the defendant; (4) whether M.C.L. 600.2169 requires an expert witness to match all specialities, subspecialities, and certificates of special qualifications that a defendant may possess, or whether the expert witness need only match those that are relevant to the alleged act of malpractice. See *Tate v Detroit Receiving Hosp,* 249 Mich App

212, 642 N.W.2d 346 (2002); and (5) what are the relevant specialities, subspecialities, and certificates of special qualifications in this case."

SUMMARY OF ARGUMENT

Amicus believes that the issues are primarily questions of statutory construction. The plain statutory language requires matching one criterion, and one criterion only, "specialty". If the expert matches board-certification in "specialty", the statutory requirements of **MCLA 600.2169** are satisfied.

In particular, the Legislature is aware of the difference between a "specialty" and subspecialty", **MCLA 333.17001(1)(a).** In contrast, **MCLA 600.2169** does not even mention, much less require matching of, any "subspecialty" or "certificate of special qualification". To answer question #2, the statutory language does **not** encompass "subspecialities" or "certificates of special qualifications", two terms that are conspicuously absent from the statute.

Likewise, in response to question # 3, **MCLA 600.2169(1)(b)** does **not** require an expert witness "to practice or teach the same subspecialty as the defendant". Instead, he must practice or teach the same "specialty".

In a similar vein, addressing question # 4, **MCLA 600.2169(1)(b)** does **not** require an expert witness "to match all specialties, subspecialties, and certificates of special qualifications". On the contrary, the statute refers to "**the** same specialty" and "**that** specialty". The Legislature's use of the definite article "the" (instead of "a") and

the word "that" (instead of "those"), and the singular term ("specialty") instead of the plural ("specialties"), advert to a **single** "specialty", not multiple specialities. If that single specialty is matched, the statutory prerequisite to giving expert testimony is satisfied. In the case of a defendant with multiple "specialities", the single "specialty" identified by the Legislature must be the "specialty" which best describes the field in which the Defendant was practicing at the time of the alleged malpractice, as the Court of Appeals held in ***Tate v Detroit Receiving Hospital*, 249 Mich App 323; 212 NW2d 346 (2002).**

Addressing question #1, the Legislature has defined the term "Board certified" in **MCLA 333.2701.** Amicus submits that it has no different meaning in **MCLA 600.2169.** For an allopathic doctor, it means "certified to practice in a particular medical specialty by a national board recognized by the American board of medical specialties" (ABMS). Likewise, a "specialty" (the term used by the Legislature) is one of the 24 fields identified as such by the ABMS and its Member Boards, in contrast to a "subspecialty", a term which describes a different and more narrow classification of medical practice.

Finally, for purposes of this case (question # 5), the relevant "specialty" is that of "pediatrics" as identified by ABMS. More narrow classifications, such as "pediatric critical care" and "neonatology-perinatology", are "subspecialties" or

"certificates of special qualification", but are not "specialities".

The statutory requirements are satisfied if the expert witness is "board-certified" in the same "specialty" as the defendant. In this case, that requirement is satisfied; both Dr. Casamassima and Dr. Custer are board-certified in pediatrics. Thus, the lower courts erred in holding that Dr. Casamissima failed to meet the expert witness requirements of **MCLA 600.2169.**

LAW AND ARGUMENT

I. BY THE LANGUAGE OF MCLA 600.2169, THE LEGISLATURE HAS EXPRESSED THE POLICY JUDGMENT THAT AN EXPERT WITNESS WHO IS BOARD-CERTIFIED IN THE SAME SINGLE "SPECIALTY" AS THE DEFENDANT IS STATUTORILY QUALIFIED, AND THE COURT SHOULD NOT CREATE A JUDGE-MADE "SUBSPECIALTY" REQUIREMENT WHICH THE LEGISLATURE ABJURED

The questions posed are primarily issues of statutory construction. They are best resolved by considering the medical-legal landscape which preceded the enactment (subsection A) and the language used by the Legislature to express the policy judgment implicit in **MCLA 600.2169** (subsection A). That language expresses the Legislature's determination not to require matching "subspecialties" or "multiple specialties", but only to require a single matching "specialty" (subsection C).

A. THE MEDICAL AND LEGAL LANDSCAPE LEADING UP TO THE ENACTMENT OF MCLA 600.2169

(1) The Role of The American Board of Medical Specialties And Its Member Boards In Board-Certification of Specialists

The classification of physicians by medical field is one example of the

practice of classifying by increasingly smaller or more narrow groups. Thus, one can speak of the broad class of all animals, or the intermediate class of dogs, or, even more specifically, the more narrow class of Labrador Retrievers. We understand that "animal control" officers may deal with dogs (even Labrador Retrievers), but may also deal with skunks, cats, and raccoons as well. A statute which requires that "dogs" be licensed does not refer to the broader group (*i.e.,* the statute does not require licensing horses), but does not apply exclusively to "Labrador Retrievers" (*i.e.,* poodles and boxers must also be licensed).

As another example, tax laws may be classified by the geographic area to which they apply: the "federal" income tax, the "Michigan" income tax, and the "Detroit" income tax. The broadest classification includes, but is not limited to, the more narrow: the "federal" income tax is imposed on those living in Detroit, Michigan, but also to those living in other cities and states. The "Michigan" income tax applies to all in the State, including Detroit, but not to Alaskans, while the "Detroit" income tax is one imposed on the most narrow of the three geographical classifications.

In the professional arena, experts having a wide variety of unique experiences may be classified in broader or more narrow groups. Those who successfully pass the Bar examination become members of the broad class of Michigan lawyers.

Of that group, some devote a substantial portion of their practices to appeals and may be characterized as "appellate specialists". Of that group, a more narrow sub-group may specialize in condemnation appeals. Again, these classifications allow a common understanding of the breadth of the group referred to. The imposition of bar dues on Michigan lawyers is understood to include, but not be limited to, "appellate specialists"; tax lawyers must also contribute. An Appellate Bench-Bar Conference is primarily of interest to "appellate specialists" (not mergers and acquisition specialists), including, but not limited to, appellate specialists who have developed a subspecialty in condemnation appeals.

Physicians may be classified, in a similar, albeit more formal fashion. At the broadest level, the class of Michigan doctors is comprised of all who have successfully satisfied licensure requirements. An intermediate classification is that of "specialist"; a doctor who has concentrated his or her efforts (or, if "board certified", has achieved certification in) a "specialty", such as "pediatrics". A more narrow classification still is that of "subspecialty", such as "neonatology-perinatology". The process by which physicians achieve the classification of "specialist" by becoming "board-certified", is explained by the websites of the American Board of Medical Specialties ("ABMS") and its osteopathic counterpart, the American Osteopathic Association ("AOA"); www.abms.org and www.ostopathic.org respectively.

As Amicus understands the process, the State oversees physician licensure. Those who achieve licensure are free to limit their practice or identify the areas of practice in which they concentrate, without any limitations imposed by the State or any voluntary group of medical practitioners.

To be designated "board certified", however, one must undergo training in an area of specialty and pass an examination in the specialty field. The predominate medical groups which oversee board-certification are the AOA and ABMS.

The AOA website lists 23 "Specialty Affiliates" (see Ex. 1) under the legend:

> "A number of organizations work to represent various osteopathic specialities and subspecialties. Contact any one of these specialty groups to learn more about how they promote the practice of osteopathic medicine" (emphasis supplied).

Among the identified "specialty groups", for the specialty "Pediatrics", is the American College of Osteopathic Pediatricians. There is no "specialty" of "pediatric critical care medicine" or "neonatology-perinotology".

The ABMS website identifies that organization as the umbrella organization for medical specialty boards, established in 1933. It consists of "Member Boards" in 24 designated specialties (Ex. 2). Again, the designated specialty Board is "Pediatrics"; there is no separate "pediatric critical care medicine" or "neonatology-

perinotology" "specialty". The ABMS has issued, "The Significance of Certification in Medical Specialties: A Policy Statement" (Ex. 3). Like the AOA legend, it uses the separate terms "specialty" and "subspecialty", stating:

> "Many thoughtful observers, both within and outside of the profession, caution that the progressive fragmentation of medicine into more and more medical **specialties and subspecialties** is contrary to the best interests of the public. Nevertheless, the **established specialty boards** as well as the American Board of Medical Specialties itself increasingly are facing concerted pressure to offer certification in additional **specialties** or **subspecialty** categories. This is occurring despite the fact that **accredited education programs and the evaluative examinations on which general certifications are based assign appropriate emphasis to each of the subspecialties or areas of special competence identified with the corresponding primary field. Accordingly, diplomates holding general certification normally acquire, to a greater or lesser degree, all of such special competencies in their educational and specialty practice experience.**
>
> **There is no requirement or necessity for a diplomate in a recognized speciality to hold a special certification in subspecialty of that field in order to be considered qualified to include aspects of that subspecialty within a specialty practice. Under no circumstances should a diplomate be considered unqualified to practice within an area of a subspecialty solely because of lack of subspecialty certification.**
>
> Specialty certification in a subspecialty is of significance for physicians preparing for careers in teaching, research, or practice restricted to that field. **Such special certification** is a recognition of exceptional expertise and experience and

> has not been created to justify a differential fee schedule or to confer other professional advantages over other diplomates not so certified." (emphasis supplied)

In addition to the 23 or 24 specialities recognized by the ABMS and AOA,[3] there are over 100 "subspecialties" recognized and certified by these groups, and about 180 "self-designated" "boards" [*Woodard v Custer*, **473 Mich 856 ; ___ NW 2d ___ (2005)** (Weaver J., concurring in leave grant). These "self-designated" "boards" apparently answer to no governmental or professional authority. Thus, two doctor-partners could designate themselves the "Bay City Board of Seventh Avenue Proctologists" and confer upon themselves some "subspecialty" designation.

(2) The Legal Landscape

MRE 702, the Rule of Evidence regarding expert witnesses generally, reposes considerable discretion in a trial judge. ***Siirila v Barrios*, 398 Mich 576, 591; 248 NW2d 171 (1976)**; ***People v Whitfield*, 425 Mich 116, 123; 388 NW2d 206 (1986).** Cases arising under that Rule, or its common law equivalent, allowed expert medical testimony from witnesses whose backgrounds were sometimes thought inadequate. See *e.g.* ***Siirila*** (pediatrician allowed to testify against general practitioner); ***Croda v Sarnacki*, 106 Mich App 51, 60; 307 NW2d 728, (1981),**

---

[3]The specialty organizations recognized by the two groups are not identical, but are largely the same from one organization to the other (compare Ex. 1 and Ex. 2).

rev'd **on other grds, 414 Mich 882; 322 NW2d 712 (1983)** (expert witness need not be a gynecologist to testify in a medical malpractice case); ***Wolak v Walczak*, 125 Mich App 271, 276; 335 NW2d 908 (1983)** (a witness need not be board-certified). Self-evidently, one purpose of **MCLA 600.2169** was to narrow the field of expert witnesses in medical malpractice cases by requiring something more than medical licensure itself. Accordingly, the Legislature required a degree of "match" between the credentials of the defendant and those of the witness.

In formulating the requisite degree of "match", the Legislature was faced with public policies against erecting undue barriers to those seeking justice. In several contexts, Michigan law seeks to promote access to our courts. For example, the "Access of Justice" program of the State Bar serves that goal, as do the thousands of hours Michigan lawyers contribute to *pro bono* legal work. **MCR 2.002** provides for the waiver or suspension of fees for indigents. In this and other settings, a legal system which prides itself on "Equal Justice Under Law" promotes the public policy of preserving access to the courts.

Maintaining meaningful access to justice in medical malpractice cases is particularly vexing. For understandable reasons,[4] few doctors are willing to speak out

---

[4]Those who testify against their colleagues may be professionally ostracized. In fact, (continued...)

about the mistakes of their colleagues. The pool of physicians willing to testify for those victimized by medical negligence is limited under all circumstances.

Moreover, doctors may possess a wide variety of specialities, sub-specialities, certificates, and the like from ABMS Member Boards and countless "self-designated" groups. Some combinations and permutations may be unique. Some may be awarded by "self-designated" "boards" in obscure fields, with little, if any, testing for special competence. To insist on matching subspecialties or multiple specialities would effectively provide many doctors with *de facto* immunity from suit, regardless of how egregious or injurious their medical negligence may have been. In ***Tate v Detroit Receiving Hospital*, 249 Mich App 212, 219; 642 NW2d 346 (2002)**, the Court of Appeals adverted to this point:

> "Certainly § 2169 cannot be read or interpreted to require an exact match of every board certification held by a defendant physician. Such a 'perfect match' requirement would be an onerous task and in many cases make it virtually

---

[4](...continued)
they may face retaliation in the form of professional discipline charges. They may also believe it is in their economic interest to remain uninvolved, believing that malpractice insurance rates will increase if the plaintiff is successful, or that, by remaining silent, other doctors will be equally unwilling to criticize their own errors. On a more benign note, their natural sympathies may lie with their defendant counterpart, or they may simple lack the stomach for the spirited and public attack they are likely to be put through by the defense attorney. While **MCLA 600. 2169** addresses expert witness qualifications for those testifying on behalf of patient and doctor alike, the practical burden of obtaining supportive expert testimony falls far more heavily on plaintiffs as a class.

> impossible to bring a medical malpractice case. Surely the Legislature did not intend to eradicate a plaintiff's ability to bring a meritorious malpractice action against a defendant physician who happens to have board certification in several different fields." (footnote omitted)

With these competing considerations in mind, the Legislature turned to the task of "tightening up" expert witness requirements, yet not abolishing professional negligence actions altogether, providing physicians with *de facto* immunity, or unduly limiting access to justice. It could classify and qualify expert witnesses by the broad category "licensed physicians", the narrow category "subspeciality", or the intermediate classification "specialty". In formulating language to articulate the degree of "match" to properly balance these considerations, the Legislature could also draw upon pre-existing statutes.

In 1986, when **MCLA 600.2169** was enacted, and in 1993 when it was amended,[5] the AOA and ABMS organizations, and their board-certification programs, were well-established. The statutory term "board-certified" had already been defined in the Public Health Code, **MCLA 333.2701(a)**, with specific reference to the AOA and ABMS classifications:

---

[5]The 1986 version allowed testimony from a witness who practiced in the same specialty "or a related, relevant area of medicine" who devoted a "substantial portion" of his or her time to that practice. The 1993 amendments deleted the "related relevant" and "substantial portion" language to the present form, which requires the devotion of a "majority" of time to the "same specialty".

"As used in this part:

(a) 'Board certified' means certified to practice in a particular medical specialty by a national board recognized by the American board of medical specialties or the American osteopathic association."

When **MCLA 600.2169** was drafted, the Legislature had also previously enacted **MCLA 333.17001(1)(a) (ii)(A)**,[6] which defined "academic institution" as including a hospital which met certain requirements. Among the statutorily specified requirements is, "that at least 1 of the residency programs is in the **specialty** area of medical practice, or in a **specialty** area that includes the **subspecialty** of medical

---

[6]In full, **MCLA 333.17001(1)(a)(ii)(A)** states:

"Sec. 17001(a) As used in this part:

(a) 'Academic institution' means either of the following:

(i) A medical school approved by the board.

(ii) A hospital licensed under article 17 that meets all of the following requirements:

(A) Was the sole sponsor or a co-sponsor, if each other co-sponsor is either a medical school approved by the board or a hospital owned by the federal government and directly operated by the United States department of veterans' affairs, of not less than 4 postgraduate education residency programs approved by the board under section 17031(a) for not less than the 3 years immediately preceding the date of an application for a limited license under section 16182(2)(c) or an application for a full license under section 17031(2), provided that at least 1 of the residency programs is in the specialty area of medical practice, or in a specialty area that included the subspecialty of medical practice, in which the applicant for a limited license proposes to practice or in which the applicant for a full license has practiced for the hospital."

practice, in which the applicant for a limited license proposes to practice or in which the applicant for a full license has practiced for the hospital" (emphasis supplied).

In short, when articulating language to describe the degree of "match" in **MCLA 600.2169,** the Legislature had already defined "board-certified" as incorporating the AOA and ABMS classification systems. Those organizations, like the Legislature itself in **MCLA 333.17001**, recognized the difference between "specialty" and "subspecialty" in defining the breadth or narrowness of a group of physicians.

B. THE LANGUAGE CHOSEN BY THE LEGISLATURE IN MCLA 600.1629 REQUIRES MATCHING A SINGLE "SPECIALTY"

As an overview, **MCLA 600.2169(1)(a)** expresses the "match" requirement which lies at the heart of this appeal. Subsections (1)(b) and (c) impose "majority of professional time" requirements. Other provisions, not directly involved in this appeal, specify criteria for judging the qualifications of an expert witness [**MCLA 600.2169(2)**],[7] and permit the court to disqualify, on other grounds, an

---

[7]**"Qualifications of expert witness; criteria.** (2) in determining the qualifications of an expert witness in an action alleging medical malpractice, the court shall, at a minimum, evaluate all of the following:

(a) The educational and professional training of the expert witness.

(b) The area of specialization of the expert witness.

(continued...)

expert witness who meets the statutory criteria of (1)(a), (b), and (c) [**MCLA 600.2169(3)**].[8]

In sharp contrast to **MCLA 333.17001(a)(ii)(A), MCLA 600.2169 (1)** uses only the term "specialty", not "subspecialty", to describe the degree of "match" required of expert witnesses. More particularly, **MCLA 600.2169(1)(a)** uses the following language to describe the relevant criterion:

> "If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in **the same specialty** as the party against whom or on whose behalf the testimony is offered. However, **if the party** against whom or on whose behalf the testimony is offered **is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty**."

Subsection (b) likewise looks only to the "specialty" of the witness:

> "Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted **a majority of his or her professional time** to either or both of the following:

---

[7](...continued)

(c) The length of time the expert witness has been engaged in the active clinical practice of instruction of the health profession or the specialty.

(d) The relevancy of the expert witness's testimony."

[8]"**Disqualification of expert witness; power of court on grounds other than qualifications stated in section.** (3) This section does not limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section."

> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if **that party is a specialist, the active clinical practice of that specialty**.
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, **if that party is a specialist**, an accredited health professional school or accredited residency or clinical research program in **the same specialty**." (emphasis supplied)

As is readily apparent, the Legislature has required only that the expert witness be a member of, and devote a majority of his or her time to, the "specialty" of the defendant. The language used by the Legislature, unlike that of **MCLA 333.17001(1)(a)(ii)(A)**, does not include "subspecialty" among the limitations.

C. THE STATUTORY LANGUAGE OF MCLA 600.2169(1), WHICH THIS COURT SHOULD RESPECT, REQUIRES AN EXPERT WITNESS TO MATCH A SINGLE ("THAT") "SPECIALTY"; IT DOES NOT REQUIRE MATCHING "SUBSPECIALTIES" OR MULTIPLE SPECIALTIES

The Court of Appeals regarded the trial court's exclusionary decision as "discretionary" in nature. That may be an apt description of a ruling under **MRE 702**

regarding allowance of an expert opinion. It might even correctly describe a decision on expert qualification under **MCLA 600.2169(2)** or **MCLA 600.2169(3).**[9] However, it is an inaccurate description of the standard of review of a decision predicated on the language of a statute.

In ***People v Lukity*, 460 Mich 484, 488; 596 NW2d 607 (1999),** this Court explained that the invocation of "discretion" does not entail a deferential standard of review in determining the meaning of a statute:

> "The decision whether to admit evidence is within the trial court's discretion; this Court only reverses such decision where there is an abuse of discretion. *People v Starr*, 457 Mich 490, 494; 577 NW2d 673 (1998). However, decisions regarding the admission of evidence frequently involve preliminary questions of law, e.g., **whether a rule of evidence or statute precludes admissibility of the evidence. This Court reviews questions of law de novo**.

---

[9]Subsections (2) and (3) seemingly enable a trial judge to exclude an expert witness who satisfies the criteria of sub-section (1). In view of the questions presented, Amicus does not address the grounds, if any, that would justify disqualifying an expert witness who is board-certified in the same specialty as the defendant.

Defendant or medical Amici may contend that "matching" a "specialty" only does not adequately assure that the opinions offered are reliable. The wisdom or lack of wisdom of the Legislature is of no moment if, as Amicus contends, the statutory language is clear. More to the point, the availability of alternative grounds for exclusion under subsections (2) and (3) demonstrates why the Court need not do violence to the language of subsection (1) to allow for disqualification of witnesses who satisfy the "specialty" criteria of subsection (1) but might be thought disqualified for other reasons. Stated differently, the prospect of disqualification under subsection (2) or (3) may explain why the Legislature required only matching the "specialty" under subsection (1), rather than some more onerous demand.

People v Sierb, 456 Mich 519, 522; 581 NW2d 219 (1998)."

Here, the questions posed focus on the meaning of the language employed by the Legislature. These questions of statutory construction are reviewed by the Court *de novo*. ***Kreiner v Fischer*, 471 Mich 109, 129; 683 NW2d 611 (2004); *In re MCI*, 460 Mich 396, 413; 596 NW2d 164 (1999).**

As this Court has often stressed, where legislative language is clear, the judicial duty is to apply the literal language, regardless of how wise the legislation may seem. ***Kreiner; supra*; *Sun Valley Foods Co v Ward*, 460 Mich 230, 236; 596 NW2d 119 (1999); *Mudel v Great A & P Tea Co*, 461 Mich 691, 706; 614 NW2d 607 (2000); *Scarsella v Pollak*, 462 Mich 547, 555; 607 NW2d 711 (2000).**

As a corollary to that principle, a court cannot create judge-made exceptions or limitations which the drafters did not decide to include. ***In re Hurd-Marvin Drain*, 331 Mich 504, 509; 50 NW2d 143 (1951); *Ford Motor Co v Unemployment Compensation Commission*, 316 Mich 468, 473; 25 NW2d 586 (1947); *Alexander v MESC*, 4 Mich App 378, 383; 144 NW2d 850 (1963).** With these thoughts in mind, we turn to the questions of statutory construction framed by the Court's leave Order.

(1) "Board Certified", As Used In MCLA 600.2169, Has The Same Meaning As When Used In MCLA 333.2701(a), A Diplomate of One of The 24 Member Boards of The American Board of Medical Specialties

The term "board certified" has been legislatively defined in the Public Health Code and in the laws regarding insurance. Notably, all refer to ABMS in defining "board certified".

Under the Insurance Code, **MCLA 500.2212a(4)** and **MCLA 550. 1402a(4)** define board certified as, "certified to practice in a particular medical or other professional health specialty by the American Board of medical specialties or another appropriate national health professional organization". In the Public Health Code, **MCLA 333.2701(a),** "board certified" is defined as, "certified to practice in a particular medical specialty by a national board recognized by the American Board of medical specialties or the American osteopathic association".

Comparing the definitions, the similarities are striking. First, all versions look to ABMS or its member boards for certification. Second, all refer to board-certification in, "a particular specialty". Third, none uses the term "subspeciality", or anything similar, as part of "board certification". On those central points, the

legislative definitions of "board certified" are uniform.

To the extent that there is any difference between the Insurance Code definition and the Public Health Code definition, the Public Health Code should be adopted for purposes of **MCLA 600.2169.** Both statutes relate serving public health needs and to the meaning and consequences of board-certification of the State's doctors. They should be read *in pari materia*. See ***State Treasurer v Schuster*, 456 Mich 408, 417; 572 NW2d 628 (1998)**; ***Webster v Rotary Electric Steel Co*, 321 Mich 526, 531; 33 NW2d 69 (1948)**; ***Weems v Chrysler Corp*, 448 Mich 679, 699-700; 533 NW2d 287 (1995)** (considering meaning of a term in a different statutory section); ***Little Caesar v Treasury Dept*, 226 Mich App 624, 630; 575 NW2d 562 (1997)** ("It is reasonable to conclude that words used in one place in a statute have the same meaning in every other place in the statute").

For present purposes, without probing the outermost definitional extremes,[10] "board certified", as used in **MCLA 600.2912,** looks to the ABMS

---

[10]The Insurance Code version refers to "another appropriate national health professional organization", while the Public Health Code refers to AOA (which presumably would constitute "another appropriate national health professional organization" in the case of osteopathic physicians). MTLA does not know what other "national health professional organizations" exist, or may exist in the future, and is unaware of any alternative organization whose classification system might be used for evaluating expert witness qualifications under **MCLA 600.2912.** Nor does Amicus know what "appropriate" might mean in this context. For purposes of this case, and this Brief, the ABMS classifications are applicable (leaving for (continued...)

classifications. In particular, it looks to "board certification" under the intermediate category of "speciality" rather than a more narrow class, "subspeciality". Thus, "board certified" refers to a diplomate of any of the 24 Member Boards comprising ABMS. If a defendant is board-certified by a Member Board, the witness must also be board-certified by that Member Board.

(2) "Specialty", As Used In MCLA 600.2169, Means One of The 24 Specialty Fields of Member Boards of ABSM; It Does Not Mean "Subspecialty"

(a) The Court Should Respect The Legislature's Use of The Term "Specialty", Rather Than "Subspecialty" In The Statute

The singular term "specialty", as used in **MCLA 600.2169,** refers to one of the 24 ABMS fields of board-certification, and is not synonymous with "subspecialty", "multiple specialties", or any more narrow or exclusionary classification. This is so for several reasons.

First, the statutory task of qualification is that, "the expert witness must be a specialist who is **board certified in that specialty**". Self-evidently, a "specialty"

---

[10](...continued)
another day and another case the question of classifications by other groups).

is a field in which one is "board certified". As discussed above, "board certified" refers to the ABMS classification system which identifies 24 specialties.

Secondly, by focusing on "specialty", and not requiring matching "subspecialty", the Legislature has embraced the recognition in the ABMS Policy Statement that board-certified diplomates already receive ample training, and acquire sufficient expertise, in constituent "subspecialties". The Legislature's language gives heed to the ABMS view that, "Under no circumstances should a diplomate be considered unqualified . . . within an area of subspecialty, solely because of a lack of subspecialty certificates".

Third, both ABMS and AOA treat "subspecialty" as a class different from, and more narrow than, "specialty". In **MCLA 333.17001(1)(a)(ii)(A)**, the Legislature has itself used the separate terms "specialty" and "subspecialty". In contrast, **MCLA 600.2169** uses "specialty" only, and conspicuously omits "subspecialty" from the statutory qualification test. Where the Legislature uses different terms in different statutes, the Court should respect the linguistic difference. ***Tyler v Livonia Schools (On Remand)*, 220 Mich App 697, 702; 561 NW2d 390 (1996)** ("phraseological distinctions in the subparagraphs of a statutory scheme reflect a legislative intent to treat some things differently"), *affirmed*, **459 Mich 382 (1999)**; ***Stowers v Wolodzko*, 386 Mich 119, 133-134; 191 NW2d 355 (1971).**

The trial judge in *Watts v Canady*, **253 Mich App 468, 470; 655 NW2d 784 (2002)** recognized as much when he observed:

> "[W]e presume that the Legislature was familiar with the term 'sub-specialty' when it enacted the provision, and the Legislature chose to use 'specialty', not 'sub-specialty'. We see no grounds for imposing a sub-specialty requirement when the Legislature has spoken in terms of a specialty requirement. We note that while the line between a specialty and a sub-specialty may appear to be fuzzy, the terms can be defined precisely according to the standards set forth by the AMA. [Citation omitted.]

The Court should respect the Legislature's decision to require only a matching "specialty". It should decline to create judge-made "subspecialty" requirements that the Legislature abjured.

Fourth, the meaning of "specialty", in conjunction with "board certified" in **MCLA 600.2169** can be seen by the juxtaposition of those same terms in another statute, **MCLA 333.2711(1)** which states:

> "For the programs created in section 2705 and 2707, the department shall only recruit physicians qualified or students training to become qualified in 1 or more of the following designated physician specialty areas:'
>
> (a) **Board certified,** or eligible for board certification, in **general practice**.
> (b) **Board certified,** or eligible for board certification, in **family practice**.
> (c) **Board certified,** or eligible for board certification, in **obstetrics**.

(d) **Board certified**, or eligible for board certification, in **pediatrics**.
(e) **Board certified**, or eligible for board certification, in **emergency medicine**.
(f) **Board certified**, or eligible for board certification, in **internal medicine**.
(g) **Board certified**, or eligible for board certification, in **preventive medicine**.
(h) **Board certified**, or eligible for board certification, in **psychiatry**." (emphasis supplied)

Notably, the "specialty" areas, for which one is "board certified", correspond to the 24 ABMS specialties.[11] **MCLA 333.2711(1)** treats "pediatrics" as a "speciality" area in which one is "board certified". The fact that only those fields which are among the ABMS 24 are included as "specialty" areas under **MCLA 333.2711(1)** sheds light on the Legislature's intent when using the same word, "specialty", in conjunction with "board certified" in **MCLA 600.2169.** It fortifies the conclusion that "specialty" refers to the 24 areas of practice, not the 100 or more specific "subspecialties".

Fifth, this meaning of "speciality" accommodates the goal of narrowing the pool of expert witnesses without unduly limiting access to the courts. All physicians in the State undergo an extended and rigorous course of training in basic

[11]The statute uses the separate characterizations "general practice" and "family practice" while the ABMS uses the term "family medicine". Otherwise, each of the statutory "specialty" areas mirrors an ABMS Member Board specialty.

medicine. They have typically undergone intense residencies and rotations. By the time of licensure, all doctors have a sound understanding of basic medicine.

According to the ABMS website, at the end of 1973, less than half of the doctors in the Country obtained board-certification from any of the 24 ABMS Member Boards. While the percentage has presumably increased since then, the fact remains that many doctors have no board certification at all, and are therefore excluded from the pool of potential witnesses in cases against board-certification specialists.

From the remainder, for purposes of discussion and simplicity, let us assume that the board-certified physicians are divided evenly between the 24 specialty fields, ignore multiple certifications, and ignore those who fail to meet the separate "active practice" requirement. In essence, then, about 4% of the physicians who are board-certified (less than 4% of all licensed doctors) have attained certification in a particular one of the 24 specialties. Thus, by limiting testimony to those board-certified in the same speciality, the Legislature has disqualified 96% of highly trained doctors, and restricted testimonial qualifications to the most knowledgeable 4%. Through board-certification, all pediatric specialists (to use an example) have received special training and testing in the constituent subspecialties.[12] The Legislature could,

[12]Consider as well that the statute applies to all instances of claimed medical malpractice, many of which are not particularly complicated, *e.g.* misreading an x-ray which shows the onset (continued...)

and presumably did, conclude that limiting testimony to the intermediate class of board-certified specialists, rather than the most narrow class, subspecialists, adequately limited expert witness qualification without excessively impeding access to justice.[13]

Finally, the proposed construction of "speciality" as different than "subspecialty" is consistent with the Court's decision in ***Holloran v Bhan*, 470 Mich 572; 683 NW2d 129 (2004).** In *Holloran*, the expert, like the defendant, possessed a certificate of added qualification in critical care medicine, the area which the defendant was practicing at the time of the event, a certificate which this Court characterized as a "subspecialty certificate" (**470 Mich at 575**). However, the defendant was board-certified in internal medicine, while the expert was board-certified in anesthesiology.[14] Thus, converse to this case, *Holloran* involved a matching "sub-

---

[12](...continued)
of cancer, or leaving a sponge in a patient during surgery, or amputating the wrong limb. And, in cases which are particularly complex, **MRE 702** and **MCLA 600.2912(2), (3)** enable a court to disqualify a witness who meets the statutory threshold of (1).

[13]At their most extreme, more narrow classifications would make it impossible to ever receive a trial on the merits if, for example, a doctor created a "self-designated" "board" which awarded its creator a unique "subspecialty" "certificate".

[14]In *Holloran*, the defendant was Board-certified in Internal Medicine by the American Board of Internal Medicine, one of the 24 ABMS Member Boards. The witness was board-certified by the American Board of Anesthesiology, another ABMS Member Board. The *Holloran* Opinion characterized the witness's board-certification as a different "specialty" (**470 Mich at 479**). Thus *Holloran* itself used the term "specialty" in the context of ABMS Member Boards.

specialty", but not a matching "specialty".

Based on these facts, the Court concluded that the expert was statutorily disqualified. In doing so, citing the need to enforce the literal words of legislation (**470 Mich at 576-577**), the Court focused exclusively on the defendant's board-certified specialty. In essence, the *Holloran* Court looked only to whether the "specialty" matched, despite the matching "subspecialty". The same principle applies here, where the legislative focus on matching "specialty", to the exclusion of "subspecialties" or "certificates", results in witness qualification.

(b) **The Statute Refers To A Single "Speciality", Not Multiple Specialties**

It is also noteworthy that the language does not require "matching" of multiple "specialities". Rather, it refers to "**the** same specialty" and **that** specialty". The use of the definite article "the", in the contrast to "a", bespeaks the Legislature's intent to refer to a single ("one") thing, ***Robinson v City of Detroit*, 462 Mich 439, 461-462; 613 NW2d 307 (2000).** Similarly, the term "that specialty", instead of "those specialties", requires a single match.

The same conclusion flows from subsection (2)'s requirement of "a majority of his or her professional time" devoted to "that specialty". Assume, hypothetically, that the defendant was board-certified in three distinct specialties, and

that the expert witness matched all three specialties, dividing his professional time equally among the three. If subsection (1) were construed to require multiple matching specialties, the most perfectly matching expert imaginable would be disqualified under (2) precisely because his or her multiple matching specialties do not allow devoting "a **majority** of his or her professional time" to any one ("that") of the three.

In sum, the Legislature has couched the requirement in terms of a single "speciality". It has omitted from the statutory language any "subspecialty" or "multiple specialty" requirement. The Court should construe and apply the statute as written without erecting additional barriers which the Legislature saw fit not to include.

(3) "Speciality" And "Board Certified" Do Not Include Subspecialties or Certificates of Special Qualifications

Question 2 ("whether 'specialty' or 'board-certified' includes subspecialties or certificates of special qualifications") should be answered in the negative. Otherwise, the opposite result would have been reached in ***Holloran***, for the matching "subspecialty" would have been deemed sufficient to meet the matching "specialty"

requirement.[15]

As discussed above, "specialty" and "subspecialty" are different terms, with different meanings. This Court should not ignore the difference or the Legislature's decision not to include "subspecialty" or "certificate" among the statutory requirements.

(4) MCLA 600.2169(1)(b) Does Not Require An Expert To Practice Or Teach The Same "Subspecialty" As The Defendant; It Requires Him To Practice Or Teach In The Same "Specialty"

The AOA, ABMS, and Legislature itself have recognized that "specialty" and "subspecialty" have distinct meanings,[16] and have used both terms separately. While able to include "subspecialty" within a statute when it chooses [see **MCLA**

---

[15]The ***Holloran*** Opinion recited that "The parties do not dispute that the sub-specialty certificate is not a 'board certification' for purposes of the statute". It is unclear from this passage whether the parties purportedly stipulated to that point or whether this was the Court's conclusion on a point on which no party differed with the Court. In all events, a court is not bound by the parties' attempt to stipulate to the law. ***In re Finlay Estate*, 430 Mich 590, 595; 424 NW2d 272 (1988); *Wilson v Gauck*, 167 Mich App 90, 95; 421 NW2d 582 (1988).** Thus, ***Hollaran*** must be viewed as the Court's own conclusion that a subspecialty certificate does not constitute a "board-certified" "specialty".

[16]Returning to the earlier discussion of classifications generally, the defense argument is akin to the suggestion that the Legislature, by using the phrase "dogs", would really mean "Labrador Retrievers (but not collies or poodles)", or that the term "Michigan" resident was intended to describe only those living in East Lansing. As in those examples, a reference to a broader classification does not mean a smaller sub-group.

333.17001(1) (a)(ii)(A)], the Legislature did not see fit to use that term to describe the required field of teaching or practice in the prior year under **MCLA 600.2169(1) (b).** Instead the requirement is characterized as "that speciality" and "the same specialty".

Turning to question #3 identified in the leave Order, **MCLA 600.2169 (1)(b)** does **not** require an expert witness to practice or teach the same "subspecialty" as the defendant. Rather, the text requires only that the expert teach or practice in the same "specialty". The Court should respect the Legislature's decision only to require a matching "specialty" and not to require matching "sub-specialties".

(5) MCLA 600.2169 Does Not Require An Expert Witness To Match All Specialties, Sub-specialties, And Certificates of Special Qualifications That A Defendant May Possess

The above discussion applies with equal force to this question. The plain statutory language requires only matching a single "specialty". It does not even mention, much less require, matching "multiple specialties", "subspecialties" or "certificates of special qualification". If the "speciality" is matched, the witness satisfies the requirements of (1) and (2).

For the most part, the twenty-four designated specialties of board-

certification are distinct areas of medical practice that have little, if any, overlap. For example, those practicing in the specialty of "Psychiatry - Neurology" provide different treatment, to different patients, than those who are specialists in "Thoracic Surgery".

Nonetheless, there is nothing to prevent a physician from becoming board-certified in Psychiatry and Neurology and also in Thoracic Surgery. Or, one might be board-certified in two specialties that can overlap, such as Pediatrics and Surgery. In those settings, the statutory focus on a single specialty ("the same specialty", "that specialty") does not answer the question of which of the two specialties the expert is to be board-certified in.

Under the most liberal approach to admissibility, where the defendant is board-certified in two specialties, an expert witness who is board-certified in either meets the statutory test, regardless of the field in which the defendant was practicing at the time. Thus, even if the defendant was practicing Psychiatry at the time, but was also board-certified in Thoracic Surgery, a thoracic surgeon would qualify as an expert witness under the literal statutory test ("if the [defendant] is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty"). The anomaly of that view is largely alleviated by the observation that a thoracic surgeon might satisfy subsection (1), but the testimony would nonetheless be subject to exclusion under (2) and (3) and **MRE 702** [see ***Craig v Oakwood Hospital***,

471 Mich 67, 77-85; 684 NW2d 296 (2004)]; *Gilbert v Daimler Chrysler*, 470 Mich 749; 779-791; 685 NW2d 391 (2004)].

The more sensible view is that, where the defendant is board-certified in two specialties, the expert must be board-certified in the specialty being practiced at the time of the alleged malpractice. ***Tate, supra.***

That view can readily be reconciled with the statutory language. The particular language in issue begins with the premise, "if [the defendant] is a specialist" before ending with the requirement of expert board certification in "that **specialty**". In this context, the word "specialist", when referring to the defendant, may be viewed as meaning, "if the defendant was practicing a board-certified specialty at the time", thus better identifying "that specialty" in which the witness must be board-certified. This sensible interpretation of "specialist" (in light of the specialty then being practiced) provides the textual basis for construing the single "specialty" required by the terms "the same specialty" and "that specialty" as the specialty being practiced at the time of injury, where the defendant is board-certified in multiple specialties.

In sum, to answer question # 4, the statute does **not** require an expert witness to match "all specialties". Rather, the expert must match only one "specialty". Where the defendant is board-certified in multiple specialties, the specialty which the expert must match is that which best describes the specialty in which the doctor was

practicing at the time of the conduct in issue.

(6) The Relevant "Specialty" For Purposes Of This Case Is "Pediatrics" Or "Pediatric Medicine"

Under the ABMS formulation, the AON formulation, and **MCLA 333. 2711(1),** "pediatrics" is a "specialty". In contrast, "pediatric critical care" and "neonatology-perinatology" are not "specialties", but may be "subspecialties" or "certificates of special qualifications".

Under **MCLA 600.2169**, the statutory expert witness qualification is board-certification in the "specialty" possessed by the defendant, in this case, "pediatrics". Dr. Casamassima meets this requirement; he is also board certified in pediatric medicine. He therefore satisfied the qualification requirements of **MCLA 600.2169(1),** and any other purported shortcomings in his training go to the weight of his testimony, but not his statutory qualification to testify.

CONCLUSION

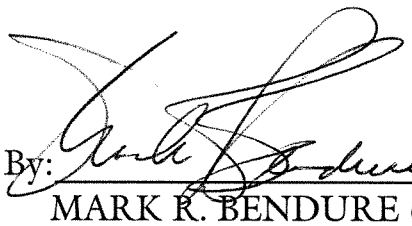
To summarize, and to address the questions identified in the Order granting leave: "Board certified" has the same meaning in **MCLA 600.2169** that is has in **MCLA 333.2701(a).** "Specialty" refers to the 24 "specialty" areas in which ABMS Member Boards provide board-certification to diplomates; it does not include "subspecialties" or "certificates of special qualification". Thus, **MCLA 600.2169(1)** requires that an expert witness be board-certified in the same one of these 24 specialties as the defendant (or, where the defendant is board-certified in multiple specialties, the single specialty which best describes the field in which the defendant was practicing at the time of the alleged malpractice).

The language used by the Legislature does not require that the expert practice or teach in any particular "subspecialty" or to match additional "specialties" "subspecialties" or "certificates". If the "specialty" matches, the expert witness meets the statutory qualification requirements. The Court should respect the language chosen by the Legislature to achieve this result, and the public policy judgment implicit in that language, and should not create additional "subspecialty" hurdles the Legislature chose not to erect.

In this case, the relevant "specialty" is pediatrics. The expert witness matches that specialty. The Court of Appeals erred in construing the statute as requiring disqualification of Dr. Casamassima.

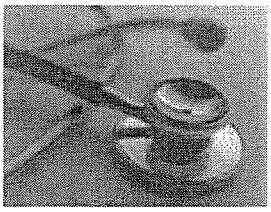
Respectfully submitted,

MICHIGAN TRIAL LAWYERS ASSOCIATION



By: _____
MARK R. BENDURE (P23490)
Attorney for Amicus
645 Griswold, Suite 4100
Detroit, Michigan 48226
(313) 961-1525

Dated: September 6, 2005



American Osteopathic Association

Home

About the AOA

About Osteopathic Medicine

About Your D.O.

About Your Health

Publications and Advertising

Media Center

Government Policy

Local & Community Resources
- State Medical Associations
- Specialty Medical Societies
- Affiliated Organizations
- Accredited Health Facilities

FAQs

Contact Us

Specialty Affiliates

A number of organizations work to represent various osteopathic specialties and subspecialties. Contact any one of these specialty groups to learn more about how they promote the practice of osteopathic medicine.

- Academy
- Addiction Medicine
- Allergy and Immunology
- Anesthesiology
- Dermatology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Medical Informatics
- Neurologists and Psychiatrists
- Obstetrics and Gynecology
- Occupational and Preventive Medicine
- Orthopedics
- Ophthalmology and Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Proctology
- Radiology
- Rheumatology
- Sclerotherapeutic Pain Management
- Sports Medicine
- Surgery

American Academy of Osteopathy

Please visit the AAO's Web site at http://www.academyofosteopathy.org or call (317) 879-1881 for more information.

American Osteopathic Academy of Addiction Medicine

142 E. Ontario Street
Chicago, IL 60611
(312) 202-8162
Fax: (312) 202-8480

2

American Board of Medical Specialties®

Member Boards and Associate Members

Member Boards
American Board of...

Allergy & Immunology 510 Walnut Street Suite 1701 Philadelphia, PA 19106-3699 (215) 592-9466	*Anesthesiology* 4101 Lake Boone Trail Suite 510 Raleigh, NC 27607-7506 (919) 881-2570	*Colon & Rectal Surgery* 20600 Eureka Road Suite 600 Taylor, MI 48180 (734) 282-9400
Dermatology Henry Ford Health System 1 Ford Place Detroit, MI 48202-3450 (313) 874-1088	*Emergency Medicine* 3000 Coolidge Road East Lansing, MI 48823-6319 (517) 332-4800	*Family Medicine* 2228 Young Drive Lexington, KY 40505-4294 (859) 269-5626
Internal Medicine 510 Walnut Street, Suite 1700 Philadelphia, PA 19106-3699 (215) 446-3500	*Medical Genetics* 9650 Rockville Pike Bethesda, MD 20814-3998 (301) 634-7315	*Neurological Surgery* Suite 2139 6550 Fannin Street Houston, TX 77030-2701 (713) 441-6015
Nuclear Medicine 4555 Forest Park Blvd., Suite 119 St. Louis, MO 63108 (310) 825-6787	*Obstetrics & Gynecology* 2915 Vine Street, Suite 300 Dallas, TX 75204 (214) 871-1619	*Ophthalmology* 111 Presidential Blvd, Suite 241 Bala Cynwyd, PA 19004-1075 (610) 664-1175
Orthopaedic Surgery 400 Silver Cedar Court Chapel Hill, NC 27514 (919) 929-7103	*Otolaryngology* 3050 Post Oak Blvd., Suite 1700 Houston, TX 77056 (713) 850-0399	*Pathology* P.O. Box 25915 Tampa, FL 33622-5915 (813) 286-2444
Pediatrics 111 Silver Cedar Court Chapel Hill, NC 27514-1651 (919) 929-0461	*Physical Medicine & Rehabilitation* 3015 Allegro Park Lane SW Rochester, MN 55902-4139 (507) 282-1776	*Plastic Surgery* Seven Penn Center, Suite 400 1635 Market Street Philadelphia, PA 19103-2204 (215) 587-9322
Preventive Medicine 330 South Wells Street, Suite 1018 Chicago, IL 60606-7106 (312) 939-2276	*Psychiatry & Neurology* 500 Lake Cook Road, Suite 335 Deerfield, IL 60015-5249 (847) 945-7900	*Radiology* 5441 East Williams Blvd., Suite 200 Tucson, AZ 85711 (520) 790-2900
Surgery 1617 John F. Kennedy Blvd., Suite 860 Philadelphia, PA 19103-1847 (215) 568-4000	*Thoracic Surgery* 633 N. St. Clair St., Suite 2320 Chicago, IL 60611 (312) 202-5900	*Urology* 2216 Ivy Road, Suite 210 Charlottesville, VA 22903 (434) 979-0059

Certification

At its September 1975 Interim Meeting, the ABMS adopted a policy statement which recognized both the opportunities and the problems in continuing specialization and subspecialization. The entire statement follows:

The Significance of Certification in Medical Specialties: A Policy Statement

A. General Principles

Medical specialty certification in the United States from its inception has been a voluntary process. Since the establishment of the first nationally recognized medical specialty board in 1917, some physicians have elected to seek formal recognition of their qualifications in their chosen specialty fields by presenting themselves for examination before specialty boards comprised of their professional peers. The definitions of each of the specialties and of the educational and other requirements leading to eligibility for board certification have been developed by consensus within the medical profession and, to date, the certification of a medical specialist has remained separate and distinct from licensure by civil authorities of professionals qualified to practice medicine within their jurisdictions.

The voluntary nature of specialty certification is attested to further by the fact that as of December 31, 1973, only 46 percent of the 308,127 physicians not in training included in the national registry of physicians maintained by the American Medical Association are diplomates of one or more of the 22 [currently 24] Member Boards of the American Board of Medical Specialties.(1) Yet, as Levit, et al., have recently demonstrated, the trend toward specialty board recognition is accelerating and during the current decade "virtually all United States graduates will undertake residency training and seek specialty certification. (2)

The growth in medical specialty certification must be differentiated from the parallel increasing trend of physicians to voluntarily designate special areas of interest or areas of special practice to which they devote the largest segment of their professional time, whether or not they are diplomates of the 22 [currently 24] Member Boards of the American Board of Medical Specialties. For such purposes the American Medical Association has expanded its list of specialty designations to 67 categories to assist the individual physician in describing his primary field of medicine for listing in the American Medical Directory. There are no professional or legal requirements for a licensed physician to seek specialty board certification in order to offer professional services in a specialty.

Many thoughtful observers, both within and outside of the profession, caution that the progressive

fragmentation of medicine into more and more medical specialties and subspecialties is contrary to the best interests of the public. Nevertheless, the established specialty boards as well as the American Board of Medical Specialties itself increasingly are facing concerted pressures to offer certification in additional specialty or subspecialty categories. This is occurring despite the fact that accredited educational programs and the evaluative examinations on which general certifications are based assign appropriate emphasis to each of the subspecialties or areas of special competence identified with the corresponding primary field. Accordingly, diplomates holding general certification normally acquire, to a greater or lesser degree, all of such special competencies in their educational and specialty practice experience.

There is no requirement or necessity for a diplomate in a recognized specialty to hold special certification in a subspecialty of that field in order to be considered qualified to include aspects of that subspecialty within a specialty practice. Under no circumstances should a diplomate be considered unqualified to practice within an area of a subspecialty solely because of lack of subspecialty certification.

Specialty certification in a subspecialty field is of significance for physicians preparing for careers in teaching, research, or practice restricted to that field. Such special certification is a recognition of exceptional expertise and experience and has not been created to justify a differential fee schedule or to confer other professional advantages over other diplomates not so certified.

Concentration of practice in a field acceptable for the award of a certificate of special competence may connote expertise in the use of special devices, techniques, or methodologies associated with that field. However, recognition of a subspecialty by the American Board of Medical Specialties must be based on broader principles than such expertise alone. The essential nature of an accepted discipline relates to the body of knowledge or philosophy of action which it encompasses.

Physicians wishing voluntarily to limit their practices to the use of special devices and techniques or methodologies are free to do so, but if they wish to have specialty board certification, it should be within one of the specialties which includes the use of the related device, technique, or methodology, along with the more basic body of knowledge that is applied through their use.

Approval of a new area for special certification, sometimes identified as subspecialty certification or as certification of special competence, signifies that there has been a thorough and critical review of the proposals by the Committee on Certification, Subcertification, and Recertification, by the Executive Committee, and by the full Membership of the ABMS. This critical review includes recognition of the fact that such approval is accompanied by related decisions by educational institutions to provide training in such areas.

B. The Responsibility for Self-Regulation of Specialization in Medicine

The ABMS shall have the responsibility to establish standards for the approval of new specialties and subspecialties. In fulfilling this responsibility, the ABMS will develop generic criteria for admission to the certificat ion process and develop guidelines for Boards to conform to generally accepted standards.

The purpose of subspecialty certificates is to establish standards of preparation to be required of those individuals who wish to provide care to the public in a subspecialty area that the ABMS has determined is of sufficient importance to be so designated.

The ABMS shall review on a regular basis all basic board certifications and all subspecialty certifications. The purpose of the review is to ensure that commonly shared goals and standards of the ABMS are maintained and that the original purposes of certification continue to exist and continue to be met. Initiation of an action by a Member Board to withdraw existing certification in a presently established subspecialty should be encouraged if appropriate.

It is the policy of the ABMS that recognition of subspecialty certification should be primarily for individuals who are devoting a major portion of their time and efforts to that restricted special field. Subspecialty certification should be granted only after education and training or experience in addition to that required for general certification in the discipline.

Adopted by the ABMS Assembly, 9/18/75
Revised 9/23/93

(1) Medical School Alumni, Aspen Systems Corporation, Rockville, MD, 1975. (2) Levit, E.J., Sabshin, M., and Mueller, C.B., Trends in Graduate Medical Education and Specialty Certification, : N Engl J Med 290:545-549, March 7, 1974.

Recertification

The continued competence of physicians has always been a major concern of the ABMS and its predecessor, the Advisory Board for Medical Specialties.

At its March 1973 Annual Meeting, the ABMS membership took the following action:

STATE OF MICHIGAN
IN THE SUPREME COURT

JOHANNA WOODARD and STEVEN WOODARD Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor,

Plaintiffs/Cross-Appellants,

vs.

JOSEPH R. CUSTER, M.D.,

Defendant/Cross-Appellee,

and

JOHANNA WOODARD and STEVEN WOODARD, Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor

Plaintiffs/Cross-Appellants,

vs.

UNIVERSITY OF MICHIGAN MEDICAL CENTER,

Defendant/Cross-Appellee.

Supreme Court Docket: 124994-95

Court of Appeals Docket: 239868

Washtenaw Circuit Court No: 99-5364-NH

CONSOLIDATED WITH

Court of Appeals Docket: 239869

Court of Claims No: 99-17432-CM

PROOF OF SERVICE

STATE OF MICHIGAN)
)ss.
COUNTY OF WAYNE)

DEBORAH JOHNSON, being first duly sworn, deposes and says that on the 6th day of September, 2005, she caused to be served, **Amicus Curiae Brief of**

the Michigan Trial Lawyers Association, Exhibits and Proof of Service, upon:

KEVIN P. HANBURY, ESQ.
Hebert, Eller, Chandler & Reynolds, PLLC
30850 Telegraph Road, Suite 200
Bingham Farms, Michigan 48025

by enclosing copies of same in an envelope with first class postage fully prepaid thereon and depositing it in the U.S. mail at Detroit, Michigan.

DEBORAH JOHNSON

Subscribed and sworn to before me
this 6th day of September, 2005

KAREN M. REMLINGER, Notary Public
Wayne County, Michigan
My Commission Expires: 12/28/05